## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/05/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED			
		095014	B. WING _	<del></del>	06/19/2007			
NAME OF PROVIDER OR SUPPLIER  WASHINGTON CTR FOR AGING SVCS				STREET ADDRESS, CITY, STATE, ZIP CODE 2601 18TH STREET NE WASHINGTON, DC 20018				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION			
K 000	INITIAL COMMENTS		K 000					
K 017 SS=E	The annual Life Safety Code inspection was conducted on June 18 and June 19, 2007. The following deficency was based on observations.  NFPA 101 LIFE SAFETY CODE STANDARD		K 017	NFPA 101 Life Safety Code	Standard			
SS=E	constructed with at rating. In sprinkler required to resist the non-sprinklered bushove the ceiling, at the underside of permitted by Code waiting areas, dining areas, dining areas, dining areas, dining areas, dining the separated from walls if the gift should be separated from the sep	is not met as evidenced by: tions during the Life Safety was determined that observed in wall surfaces le:		<ol> <li>The Penetrations obsesurfaces above ceiling hallways in the 1 Orar 3rd floors of the Blue repaired and complete 6/20/07.</li> <li>The entire wall above the hallways throughed facility was checked of for penetrations.</li> <li>Monthly inspection of barrier walls is condumaintenance personne education of penetration.</li> <li>A preventive mainten program is in place is the QI Meeting.</li> </ol>	tiles in the age, 2nd & Wing was d on ceiling in but the on 6/20/07  If the smoke cted by el with re-ons			
	l .	observed in wall surfaces in the hallways and commoning locations:						

LABORATORY DIRECTORS OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 017	First Floor Dining R opening was obser double doors near one (1) observation approximately 4:00  1 Orange- A two (2 penetration were of around communication one (1) of eight (8) approximately 10:0  2 Blue- An opening observed in wall sulines above ceiling to the janitorial closs surface observation on June 19, 2007.  3 Blue- A 4 to 5 inc wall surfaces arour ceilings tiles adjaces.	coom- An eight (8) inched in wall surfaces above the Beauty Shop in one (1) of a of wall surfaces at PM on June 18, 2007.  Inch and three (3) inched been described above ceiling tiles attention wires near room 150 in wall surface observations at 0 AM on June 19, 2007.  Inapproximately 10 inches was a rfaces around chilled water tiles adjacent to the entrance set in one (1) of five (5) wall the sat approximately 11:45 AM with opening was observed in and chilled water lines above ent to the janitonal closet in one surface observations at 12:30	K 01					